STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. BUILDING: _____ B. WING _____	03/15/2021

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THE CARE CENTER OF HONOLULU	1900 BACHELOT STREET HONOLULU, HI 96817

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4 000	Initial Comments A re-licensure survey was conducted by the Office of Health Care Assurance (OHCA) on 03/09/21 to 03/15/21. The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Chapter 11-94.1. The SA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) #8510, #8516, #8719, and #8733. Although, not all allegations were not substantiated, the facility was cited for associated deficient practices at F609 (reporting allegations to adult protective services) and F610 (investigate, prevent, correct alleged violations). Survey Census: 144 Sample Size: 29	4 000		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor.	4 105		5/7/21

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4 105	Continued From page 1 This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to ensure there was accurate documentation of a pressure injury for Resident (R)99. The wound assessment documents R99 was admitted with the pressure injury; however, the documentation indicates the pressure injury was facility-acquired. Findings Include: Record review on 03/11/21 and 03/12/21 found "Weekly Wound Assessment" documenting R99 was admitted with Stage I pressure injury to the mid-back. The resident's admission progress note dated 01/27/21 does not document the presence of a pressure injury to the mid-back. There is documentation of a Stage I pressure injury to the left buttock and a Stage II pressure injury to the right buttock. A review of R99's admission Minimum Data Set with assessment reference date of 01/31/21 notes presence of one Stage I pressure injury and one Stage 2 pressure injury on admission. Interview and concurrent record review with MDS Coordinators was done on 03/12/21 at 03:35 PM. The coordinators confirmed the nursing admission assessment did not include the pressure injury to R99's mid-back. The first documentation of the pressure injury was 02/06/21 as a Stage I to Stage 2. Initially (02/03/21) the mid-back was excoriated and covered with foam dressing, the coordinator stated it was unclear why foam dressing was used. Coordinator confirmed the "Weekly Wound Assessment" documents R99 was admitted with the pressure injury to the mid-back. The coordinators confirmed based on the	4 105	4105 – Medical record System 1)Residents #99 records were reviewed regarding his wound care and care plan was updated by LN. DON educated Unit Manager on 3/12/21 regarding the need of proper documentation of skin assessment on admission and weekly as needed. 2)Residents residing in the facility have the potential to be affected. 3)DON/Designee educated Licensed Nurses on 4/29/21 and on an ongoing basis regarding maintaining weekly wound care documentation. 4)Unit Manager/Designee will review new admissions daily x 4 weeks, then weekly x 2 months to validate that proper skin assessment and documentation was done. DON/Designee will conduct audits on 10 residents requiring wound care per week x 4 weeks, then 10 residents per month x 2 months to validate maintaining weekly wound care documentation correctly. DON/Designee will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	

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4 105	Continued From page 2 documentation, R99 was not admitted with the pressure injury to the back, the wound was facility-acquired.	4 105		
4 113	11-94.1-27(2) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (2) The right to be free of interference, coercion, discrimination, and reprisal from the facility that shall include the right to be free of chemical or physical restraints not medically indicated; This Statute is not met as evidenced by: Based on observations, interviews, and staff interviews, the facility failed to ensure the resident's right to be free from any physical restraint imposed for the purpose of convenience, and not required to treat the resident's medical symptoms as evidenced by Resident (R)76's wheelchair placed tightly between a table and wall, restricting the resident from standing up and staff applying a right-handed mitten on R16, restricting the use of the resident's hands without a doctors order or care plan. As a result of this deficiency, the residents are at risk of the potential for more than minimal harm and psychosocial harm.	4 113	4113 – Resident rights and facility practices 1)Residents #76 and #16 were assessed by the DON to ensure proper care plan, procedures, and orders are in place to care for the residents and keep them safe on 3/12/21. 2)Residents residing in the facility have the potential to be affected. Current resident records were reviewed to ensure that restraint use has followed proper requirements for implementation.	5/7/21

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4 113	Continued From page 3 Finding Include: 1)On 03/09/21 at 09:50 AM, observed R76 in a common dining area seated in a wheelchair at a table which was not near the nurse's station. R76's wheelchair was positioned between a table and a wall on the unit's main dining are. The positioning of R76's wheelchair prevented R76 from moving the wheelchair in any direction or freely standing. The handlebars on the back of the wheelchair were approximately one inch away from the wall making impeding the wheelchair from backward movement and the front of the wheelchair was approximately two-three inches away from the table impeding R76 from standing for moving the wheelchair forward. Observed R76 grabbing the side of the table and attempting to stand, however, the table was too close to R76 and stopped her from fully standing, R76 was not engaged in any activities and there were no staff was in the immediate area. On 03/09/21 at 10:00 AM, inquired with Registered Nurse (RN)6 regarding R76's wheelchair being tightly placed between the table and wall, and continuous attempts to stand. RN6 stated "R76 does that." RN6 was asked to further clarify the statement and RN6 replied, R76 is always trying to stand, but the resident is confused and will fall. R76 observed seated in the wheelchair in the dining area until approximately 1:00 PM. This surveyor made a total of five observations (03/09/21 at 09:50 AM, 03/10/21 at 09:00 AM, 03/11/21 at 09:18 AM and 4:35 PM, and on 03/15/21 at 08:00 AM) R76 same position, seated in the wheelchair which was placed between a wall and a table, attempting to stand but was physically unable to due to her positioning, and	4 113	3)DON/Designee educated Licensed Staff on 4/29/21 and on an ongoing basis regarding restraints, the requirements for use of restraints, and the importance of updating residents' care plans timely. 4)DON/Designee will conduct audits on 5 residents per week x 4 weeks, then 8 residents per month x 2 months to validate that care plan is being followed and there is no inappropriate use of restraints. DON/Designee will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	

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4 113	Continued From page 4 not engaged in activities.. On 03/10/21 at 1:16 PM, two surveyors observed R76 positioned the same as described above, but this time R76 was frantically grabbing at the sides of the table, pulling at the tablecloth on the table while grabbing at the side of the table, and attempting to stand up. R76 appeared extremely distressed and frightened to both surveyors making the observation. Unit staff were assisting other residents and would occasionally go to the medication cart, which was in the line of sight or R76, prepare medications, then leave the area. Staff passing the main dining area did not stop to assess or help R76. Conducted a record review (RR) of R76's electronic medical record (EMR). R76's care plan, last reviewed on 02/12/21, documented interventions which includes that staff ensures R76 is by nurse station while in wheelchair, provide table in front with snacks or activity to utilized in keeping busy to divert attention, involve in activities that promote independence, frequent check while at nurse station due to frequently stand up and sitting, and ensure the table and chair are aligned due to poor balance when standing which were not implemented. Review of the physician orders did not document restraint orders. On 03/15/21 at 12:35 PM, conducted an interview with the Unit Manager (UM)3 regarding observations of R76' wheelchair positioned between the wall and the table which stopped R76 from freely standing. UM3 confirmed the placement of R76's wheelchair did prevent R76 from freely standing and restricted the resident's movement. Inquired if R76's wheelchair was positioned in that manner due to any medical	4 113		

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4 113	Continued From page 5 condition. UM3 stated R76 did not have a medical condition which would require the resident's wheelchair to be placed in a manner which would restrict R76 from moving. UM3 stated R76 requires constant supervision which the staff are unable to accommodate and staff have a difficult time finding activities to keep R76 engaged due to R76's level of cognition. Inquired if R76 would benefit from the implementation of dementia care. R76 confirmed specific dementia care would benefit the resident, however, the resident does not have a detailed dementia program or interventions. On 03/15/21 at 2:51 PM, conducted an interview with the Director of Nursing (DON). Shared observations of position of R76's wheelchair and restricted ability to stand freely. The DON confirmed the positioning of the wheelchair did work as a physical restraint and the facility did not implement effective interventions related to R76's dementia care. 2) On 03/09/21 at 09:28 AM, an initial observation made of R16 in her room revealed that she had on a right-hand mitten restraint. R16 also presented with a tracheostomy (a surgically formed opening into the windpipe to allow breathing) through which she was receiving oxygen. R16 was alert and made eye contact with the surveyor. R16 began rubbing her back side to side on the bed. R16 made no discernable indication of "yes" or "no" when asked if she was okay. R16 stopped rubbing her back side to side. An observation of R16 was made again at 11:38 AM and she was resting in bed calmly with her right-hand mitten restraint on. At 2:07 PM, R16 was observed to be sleeping in bed with the right-hand mitten restraint applied.	4 113		

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4 113	Continued From page 6 Further observations done of R16 on 03/10/21 09:19 AM and on 03/11/21 08:16 AM revealed R16 was calmly resting in bed with the right-hand mitten restraint applied. A record review of R16's EHR was done on 03/11/21 at 10:19 AM. According to the "Respiratory Service Note," R16 was able to decannulate her tracheostomy (remove the plastic insert maintaining the surgically formed opening to her windpipe) on 01/04/21, 02/12/21, 02/27/21 and 03/02/21. In the 01/04/21 note, the respiratory therapist (RT) recommended to the RN (registered nurse) and CNA (certified nurse assistant) the use of a right-hand mitten restraint to prevent R16 from decannulating her tracheostomy further. A continued record review revealed no care plan was documented outlining the safe use of the right-hand mitten restraint and needed resident monitoring. No limb circulation, movement and sensation (CMS) nursing assessments of R16 and assessments of the right-hand mitten restraint were found in the EHR. No alternative methods prior to the use of the right-hand mitten restraint to prevent R16 from decannulating her tracheostomy was documented. No nursing pre-assessment of R16 was documented before the continued application of her right-hand wrist restraint. The record review further revealed that a physician's order to use the right-hand hand mitten was not written by RN28 until 03/10/21 and a consent from R16's son for the use of restraints was not obtained by RN28 until 03/11/21. An interview was done with RN3 on 03/11/21 at	4 113		

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4 113	Continued From page 7 10:50 AM at the nursing station of Unit 2. She stated that there was no flowsheet done for monitoring R16 and her right-hand wrist restraint and that the restraint was supposed to be released every two hours. A review of the facility's policy "Use of Restraints" was reviewed on 03/11/21 at 2:30 PM. Several violations of their policy were found:" "5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention ..." "6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms." "9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor)." "12. The following safety guidelines shall be implemented and documented while a resident is in restraints: ...c. A resident placed in a restraint will be observed at least every (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record." "17. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the	4 113		

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4 113	Continued From page 8 symptom(s)" "18. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use." "19. Documentation regarding the use of restraints shall include: a. Full documentation of the episode leading to the use of the physical restraint. This includes not only the resident symptoms but also the conditions, circumstances, and environment associated with the episode; b. A description of the resident's medical symptoms (i.e., an indication or a characteristic of a physical or psychological condition) that warranted the use of restraints; c. How the restraint use benefits the resident by addressing the medical symptom; d. The type of the physical restraint used; e. The length of effectiveness of the restraint time; and f. Observation, range of motion and repositioning flow sheets."	4 113		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon	4 115		5/7/21

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4 115	Continued From page 9 request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure the resident's right to communicate with and access to persons outside the facility and resident's right to make choices about aspects of his/her life in the facility that are significant to the resident as evidenced by the facility did not identify and support Resident (R)25's bathing schedule preference and R117 was denied the opportunity to visit with and communicate with family members. This placed R117 at risk for a decline in her quality of life and prevented her from attaining her highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings Include: 1) On 03/09/21 at 12:01 PM, an observation was done of R117 in her room on Unit 1. R117 was observed lying in bed two, which had been positioned to angle towards the glass door. R117 was awake, staring out the glass door, with a slight smile on her face. Outside the glass door was a young woman wearing scrubs, smiling and waving repeatedly through the glass. On 03/10/21 at 11:48 AM, a phone interview was done with the daughter (DA) of R117. DA stated that she frequently calls the unit (Unit 1) to speak	4 115	4115 – Resident rights and facility practices 1)New wireless phones were purchased and installed. SSD visited resident to verify that family has been reached and resident's well-being was not affected. Resident #25's bathing schedule was reviewed by the Unit Manager (UM) and bathing time was updated per resident's preference. 2)Residents residing in the facility have the potential to be affected. All units were checked by maintenance staff to ensure that wireless phones were available for residents to utilize. Facility has continued to allow outdoor visitations per facility's guidelines. Current bath schedule preferences have been reviewed by the DON/Designee to ensure choices of each resident are honored. Newly admitted residents are asked for bathing preferences and documented on admission assessments, current LTC residents shower preferences will be reviewed quarterly and as needed. 3)Administrator/Designee educated staff on 4/29/21 and on an ongoing basis	

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4 115	Continued From page 10 to both the staff, to discuss her mother's care, and to her mother. DA reported that the cordless phone on Unit 1 had been broken for over a week, so she had not been able to talk to her mom on the phone. Since she works across the street, on days that she does not call, DA usually tries to visit. DA stated that she visited her mother yesterday (03/09/21) on her lunch. Normally, staff would get R117 up to a wheelchair, and position her next to the glass door in her room so that DA could speak to her through the glass. However, yesterday, DA stated that staff told her they were short-handed and busy with other residents, so no one could get R117 up to her wheelchair. DA was forced to only wave through the glass door to R117, as she lay in bed. DA went on to describe how this morning, both she and her sister came to visit, but staff told them that they could not get R117 out of bed, that she was too sleepy. DA questioned if this was true. DA stated she feels that if R117 knew that her daughters were there to visit, she would have gotten up out of bed. DA stated she is certain that R117 really misses her family, and that is why she tries to visit as often as possible. On 03/11/21 at 11:00 AM, an interview was done with the Ventilator Care Unit (VCU) Unit Manager, RN15, at the Unit 1 Nurses Station. Regarding phone calls for Residents, RN15 stated that the family will call the Nurses Station, "and we will transfer [the] call to [the] cordless" and take the cordless to the Resident. RN15 explained that Unit 1 has two cordless phones on the Unit, one is primarily for the Residents, and the other is supposed to be for staff, but is often used for the Residents as well. When asked if the two cordless phones were operational, RN15 admitted that they were not, and had not been	4 115	regarding the need to report broken phones to their supervisors timely, the current visitation guideline, and the importance of staff members facilitating communication between residents and family members. DON/Designee educated nursing staff on 4/29/21 and on an ongoing basis regarding the need to ensure residents shower preferences are asked and care planned 4)SSD/Designee will interview/observe 5 residents per week x 4 weeks, then 5 residents per month x 2 months to validate that residents are able to meet with their family and the wireless phone on that unit is working. DON/Designee will interview/review 5 residents per week x 4 weeks, then 5 residents per month x 2 months to validate that residents are being bathed according to their preference and a care plan is in place. SSD and DON will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	

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4 115	Continued From page 11	4 115		

operational for "about a week and a half." RN15 explained that both cordless phones were not receiving a signal and needed a new wireless modem piece. Per RN15, Maintenance was aware of the problem and had tried to fix it but was waiting on a part.

2) On 03/10/21 at 10:35 AM, an interview was done with R25 in his room on Unit 1. R25 complained that the night shift staff wake him up for baths, sometimes at 12 or 1 o'clock in the morning, and then he cannot go back to sleep. R25 stated that he tries to tell them no, that he wants to bathe during the day, but they do not listen. R25 further explained that he really does not like to bathe late at night because he is always cold.

On 03/11/21 at 08:55 AM, an interview was done with Certified Nurse Aide (CNA)24 in front of the Unit 1 Nurses Station. CNA24 confirmed that R25 is on the night shift (11:00 PM to 7:30 AM) bathing schedule.

On 03/11/21 at 09:21 AM, an interview was done with CNA53 outside of R25's room on Unit 1. Per CNA53, all residents are asked about their preference for bathing time upon admission. CNA53 went on to state that if a resident changes their mind regarding bathing time, they just need to let the nurse know.

RR of R25's Admission Notes revealed that despite multiple admissions and re-admissions, no documentation was found that R25 had ever been asked his preference for bathing time.

On 03/15/21 at 09:11 AM, an interview with the Director of Nursing (DON) was done in her office. Discussed concern with R25's preference for

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4 115	Continued From page 12 bathing time not being accommodated. The DON stated that they [Administration] had already identified that resident preferences were not being asked and documented. Further discussion at 11:03 AM confirmed that R25's preference for bathing time had been updated.	4 115		
4 131	11-94.1-29(b) Resident abuse, neglect, and misappropriation (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance with state law through established procedures. This Statute is not met as evidenced by: Based on record review and interviews, the facility failed to report allegations involving neglect or abuse to other officials in accordance with state laws as evidenced by the facility did not report an allegation of physical abuse to the Adult Protective Service (APS). Findings Include: 1) The facility submitted a report of alleged neglect to the State Agency on 10/12/20. On 10/11/20 at 07:30 PM, Certified Nurse Aide (CNA)16 reheated Resident (R)497's coffee in the microwave. R497 spilled the coffee on himself which resulted in a second degree burn to his left upper arm. A review of the FRI and the facility's investigative report found no documentation the allegation was reported to	4 131	4131 – Resident abuse, neglect, and misappropriation 1)Administrator was educated on facility's reporting policy on 3/12. 2)Reportable incidents for all residents will be submitted per OHCA guideline and the facility's Abuse Investigation and Reporting Policy and Procedure. 3)Administrator re-educated the Department Heads on the facility's policy & procedures on 4/26/21. DON/Designee educated LNs on 4/29/21 and on an ongoing basis on the importance of identifying, assessing, developing care plan interventions, about reporting	5/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. BUILDING: _____ B. WING _____	03/15/2021

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4 131	Continued From page 13 APS. Further review noted the incident occurred on 10/11/20 and the completed investigative report was done on 10/19/20, 8 (eight) days after the event. The results of the investigation report was sent to the State Agency via facsimile on 10/19/20 at 05:40 PM. A review of the calendar found the incident occurred on a Sunday (10/11/20) and completion of the investigation was done on the following Monday (10/19/20), 8 calendar days and six weekdays. The Administrator was interviewed on 03/15/21 at 09:17 AM. The Administrator confirmed the allegation of neglect was not reported to APS. Queried Administrator regarding the facility's work days, the Administrator responded work days are Monday through Friday. Informed the Administrator, investigation results were not done within five working days. A review of the Abuse Investigation and Reporting Policy and Procedures provided by the facility documents the following policy statement on page 1 (one): "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported." Further review notes on page 3 (three), "The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident". The agencies listed	4 131	allegations in a timely matter to both OHCA and APS. 4)DON/Designee will conduct audits on allegations of abuse each week x 4 weeks, then monthly x 2 months to validate proper and timely reporting. DON/Designee will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	

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4 131	Continued From page 14 above include the State Agency and Adult Protective Services. 2) On 03/12/21 at 2:00 PM, a records review of the facility's Office of Health Care Assurance (OHCA) completed event report dated 03/07/21 and the Adult Protective Services (APS) report dated 03/05/21 were done. The APS report stated that R49 sustained a "severely bruised" left arm that started at her left elbow and extended to her fingers. This incident happened at the facility on 03/01/21 and it was reported to APS on 03/02/21 by R49's receiving assisted living facility. A review of the facility's "Abuse Investigation and Reporting Policy and Procedure" on 03/12/21 at 2:30 PM revealed that APS is an agency that needs notification of an incident " ...immediately, and not later than: Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury." In an interview with the DON on 03/12/21 at 3:00 PM, she stated that she investigated this incident, but did not report it to APS. 3) On 03/15/21 at 09:16 AM, interview with Administrator confirmed that APS was not called for physical abuse incident on 02/17/21 regarding R71 and R45. Administrator did not know the state laws in Hawaii regarding reporting abuse and neglect. On 03/15/21 at 11:00 AM, Director of Nursing (DON) confirmed that the most updated Abuse Investigation and Reporting Policy and Procedure dated on 01/31/20 includes reporting to APS.	4 131		

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4 134	Continued From page 15	4 134		
4 134	11-94.1-29(e) Resident abuse, neglect, and misappropriation (e) The results of all investigations shall be reported to the administrator of the facility or the designated representative and to other officials, including the department, in accordance with state law within five working days of the incident. This Statute is not met as evidenced by: Based on record review and interviews, the facility failed to report of investigations to the appropriate departments in accordance with state law within 5 working days. Findings Include: Based on record review and interviews, the facility failed to report allegations involving neglect or abuse to other officials in accordance with state laws as evidenced by the facility did not report an allegation of physical abuse to the Adult Protective Service (APS). Findings Include: 1) The facility submitted a report of alleged neglect to the State Agency on 10/12/20. On 10/11/20 at 07:30 PM, Certified Nurse Aide (CNA)16 reheated Resident (R)497's coffee in the microwave. R497 spilled the coffee on himself which resulted in a second degree burn to his left upper arm. A review of the FRI and the facility's investigative report found no documentation the allegation was reported to APS.	4 134	4134 – Resident abuse, neglect, and misappropriation 1)Administrator was educated on facility's reporting policy on 3/12. 2)Reportable incidents for all residents will be submitted per OHCA guideline and the facility's Abuse Investigation and Reporting Policy and Procedure. 3)Administrator re-educated the Department Heads on the facility's policy & procedures on 4/26/21. DON/Designee educated LNs on 4/29/21 and on an ongoing basis on the importance of identifying, assessing, developing care plan interventions, about reporting allegations in a timely matter to both OHCA and APS. 4)DON/Designee will conduct audits on allegations of abuse each week x 4 weeks, then monthly x 2 months to validate proper and timely reporting. DON/Designee will report any identifying trends and findings to QAPI Committee for	5/7/21

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4 134	Continued From page 16 Further review noted the incident occurred on 10/11/20 and the completed investigative report was done on 10/19/20, 8 (eight) days after the event. The results of the investigation report was sent to the State Agency via facsimile on 10/19/20 at 05:40 PM. A review of the calendar found the incident occurred on a Sunday (10/11/20) and completion of the investigation was done on the following Monday (10/19/20), 8 calendar days and six weekdays. The Administrator was interviewed on 03/15/21 at 09:17 AM. The Administrator confirmed the allegation of neglect was not reported to APS. Queried Administrator regarding the facility's work days, the Administrator responded work days are Monday through Friday. Informed the Administrator, investigation results were not done within five working days. A review of the Abuse Investigation and Reporting Policy and Procedures provided by the facility documents the following policy statement on page 1 (one): "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported." Further review notes on page 3 (three), "The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident". The agencies listed above include the State Agency and Adult Protective Services.	4 134	further resolution and recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	

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4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and interview with staff members, the facility failed to ensure stored and served food were not expired and failed to check the temperature of poultry ensuring it was fully cooked prior to storing with previously established cooked poultry. As a result of this deficiency, residents are at risk of a food-borne illness and have the potential for more than minimal harm. Findings Include: 1) During the initial kitchen tour observation with Dietary Manager (DM)1 on 03/09/21 at 8:35 AM, Dietary Aide (DA) 2 had two containers of thicken dairy liquid with a best if used by date of 03/03/21 on a cart while preparing drinks for breakfast. One of the containers was opened and nearly empty. Both DA2 and DM1 looked at each other and the containers multiple times and did not reply when asked if the thicken dairy liquids were expired Further observation of the dry goods storage room observed nine additional containers of thicken dairy liquid with a best if used by date	4 159	4159 – Storage and handling of food 1)Expired thickened liquids were removed from inventory immediately. DDS educated Cook #2 on proper cooking temperatures on 3/11/21. 2)Residents residing in the facility who eats food prepared by the kitchen have the potential to be affected. 3)DDS/Designee educated dietary staff on 4/29/21 and on an ongoing basis regarding proper rotation of food supplies using FIFO inventory management and date expiration. DDS educated cooks on 4/29/21 regarding how to/when to check internal meat temperatures. 4)DDS/Designee will conduct audits 3 times per week x 4 weeks to validate cooks are taking temperatures properly for one month. DDS/Designee will check	5/7/21

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4 159	Continued From page 18 of 03/03/21. Interview with DM1 on 03/11/21 at 11:11 AM stated the facility received the thicken dairy liquid on 03/01/21 and does not understand why the vendor would deliver food that will expire in a few days without notifying the facility. DM1 further stated that kitchen staff should check expiration dates when food supplies are delivered. The containers of thicken dairy liquid was thrown out. 2) On 03/11/21 at 11:22 AM observed Cook 2 grab a tray of cooked fried chicken from the warming station and put it on the flat top griddle next to the fried chicken cooking on the stove. Cook 2 proceeded to use tongs to grab the cooking fried chicken from the pan and put in the tray of cooked fried chicken without taking the internal temperature. During an interview with Cook 2, inquired how does he know when the chicken is cooked, he replied when it turns brown. Surveyor requested for Cook 2 to take the temperature of the fried chicken he completed cooking and inquired what is the final cooking temperature of chicken to ensure it is fully cooked. Cook 2 did not respond and walked away. Cook 2 walked to the front to receive assistance from Assistant Dietary Manager (ADM) 1 who stated the temperature should be at 165 degrees Fahrenheit.	4 159	storage weekly x 4 weeks to validate proper rotation of food supplies using FIFO inventory management and date expiration. DDS/Designee will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and	4 174		5/7/21

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4 174	Continued From page 19 resident/family education. This Statute is not met as evidenced by: Based on observation, record review (RR), and interview, the facility failed to develop a baseline care plan that provided effective and person-centered care for one Resident (R)397 in the sample. Specifically, despite identifying that R397 had complicated respiratory and communication needs, the facility failed to develop, implement and modify resident-specific interventions that thoroughly addressed those needs. As a result of these deficient practices, the facility placed R397 at risk for avoidable declines and injuries. This deficient practice has the potential to affect all the residents at the facility. Findings Include: R397 was a 71-year-old admitted to the facility on 03/01/21 for long-term care services following a traumatic motor vehicle accident where he suffered a subdural hemorrhage (bleeding that occurs between the brain and its outermost covering, that is usually caused by a severe head injury), and numerous fractures (broken bones), resulting in complete paralysis from the neck down. Since R397 was still considered a new admission, he was housed in a single room, with the door closed, as per the facility Infection Control Plan. As a result of his injuries and paralysis, R397 was unable to move his head, trunk or any of his limbs, was ventilator-dependent, had lost the ability to speak, had an indwelling urinary catheter, and could not activate any type of call light. On 03/10/21 at 11:19 AM, an observation was	4 174	4174 – Interdisciplinary care process 1)Resident #397 was assessed by UM and the Baseline Care Plan was updated. 2)New residents admitted to the facility have the potential to be affected. Upon review of facility's EMR, DON is working with PCC to activate the EMR system generated baseline care plans upon admission. 3)DON/Designee educated clinical staff on 4/29/21 and on an ongoing basis regarding the requirements of Baseline Care Plans to provide effective and person-centered care for all new residents. 4)DON/Designee will conduct audits on new residents x 4 weeks, then 10 new residents per month x 2 months to validate that Baseline Care Plans are properly documented. DON/Designee will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	

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4 174	Continued From page 20	4 174		

done of R397 in his room on Unit 1. R397 was observed lying in bed, leaning to the left, his head angled to the left, eyes open, with a moderate amount of saliva both in his mouth, and running down the left side of his chin. R397 was not responsive to greetings or questions, and a call light was visible on his belly.

On 03/10/21 at 11:24 AM, an interview was done with Registered Nurse (RN) 16 at the Unit 1 Nurses Station. When describing R397, RN16 said that he cannot talk, he has an amputated right arm (at the shoulder), and that he cannot move his left arm, his legs, his feet, or his head. She said R397 had a round, flat call light, but that he cannot use it as this would require the ability to move at least one limb, or the ability to turn his head from side to side. Surveyor informed RN16 that R397 had quite a bit of saliva running down the left side of his mouth and chin. RN16 stated "yes, he needs a continuous suction to his mouth, but he keeps biting [the] tube, so we cannot keep it in continuously."

RR of R397's electronic medical record (EMR) noted that on 03/9/21 at 05:10 PM, Respiratory Therapist (RT) 23 documented in her Respiratory Service Note that she had found R397 that morning with bleeding in his mouth after biting a small yankauer (suction tube) that was left there. Noting that he was also in need of suctioning at that time, RT23 suctioned "moderate thick bloody" fluid from his mouth, and "moderated (sic) thick white" fluid from his tracheal tubing (a tube in the throat that is surgically inserted through the neck).

On 03/11/21 at 11:00 AM, an interview was done with the Ventilator Care Unit (VCU) Unit Manager, RN15, at the Unit 1 Nurses Station. When asked

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4 174	Continued From page 21 about care for residents who cannot talk, RN15 said that they "train residents" to blink for yes/no, and they also have a letter chart where they ask residents to blink for letters in order to form sentences. RN15 went on to state that the Unit has only one copy of this letter chart which is already being used by a Resident, and it is kept in her room. When asked about call lights, RN15 stated that they are issued after the admission assessment is done depending on the Resident's needs. RN15 reported he was unsure what type of call light R397 had but says he could not use any of their call lights anyway because he cannot move his head, limbs or trunk. With regards to visual checks (rounds) on Residents, RN15 stated that the Certified Nurse Aides (CNAs) and the RTs round every two hours and as needed. Although aware that R397 could not call out for help, could not use a call light, and required frequent oral suctioning, RN15 stated that R397 had not been placed on a more frequent rounding schedule. RR of R397's Baseline Care Plan confirmed that no interventions had been planned to effectively address these particular needs. In fact, keeping the call light "within reach", and encouraging the resident to "continue stating thoughts" is noted multiple times throughout the Baseline Care Plan.	4 174		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition.	4 175		5/7/21

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4 175	Continued From page 22 This Statute is not met as evidenced by: Based on observations, record reviews (RR), and interviews, the facility failed to develop and implement a comprehensive person-centered care plan (CP) for five (5) residents as evidenced by the facility did not implement the use of floor pads on both sides of the bed as an intervention for Resident (R)76 who is a high fall risk and has had a fall with major injury; did not implement dementia care interventions related to activities for R76; did not implement the use of pressure injury reduction interventions for R35 who has a history of pressure injury to the left heel; did not include an alternative means to address the mobility and range of motion (ROM) needs in his hands and feet for R25, once he signed a refusal to wear hand splints; and R117's CP did not include interventions that involved her family to help address the multiple behavioral needs identified, despite the facility knowing that it was important to R117 to have her family involved in discussions about her care. As a result of these deficient practices, these residents were placed at risk for a decline in their quality of life and were prevented from attaining their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings Include: 1) On 03/09/21 at 09:50 AM, conducted an initial observation of R76's room. Throughout the entirety of the survey, this surveyor did not observe the use of floor pads for R76. Observations were made of the resident resting in bed with no floor pads on either side of the bed, on one occasion a wheelchair was placed next to the bedside.	4 175	4175 – Interdisciplinary care process 1)Residents #76, #35, #25, #117, and #127 individual Comprehensive care plans were reviewed by MDS nurse and updated. DON educated SS staff on including family/representatives in care plan decisions. 2)Residents residing in the facility has the potential to be affected. 3)DON/Designee educated LNs on 4/29/21 and on an ongoing basis regarding completing person-centered interdisciplinary comprehensive care plans with appropriate interventions and the requirement to implement and follow the resident-specific care plan, as well as how to address when an intervention does not appear to be working. This education includes the importance of including IDT members and the resident and/or their family members/representatives when appropriate. 4)DON/Designee will conduct audits on 5 residents per week x 4 weeks, then 5 residents per month x 2 months to validate that comprehensive care plans are reviewed for appropriate interventions, and then will conduct observation audits of care being provided on those residents to ensure the care plan is being followed. DON/Designee will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance	

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4 175	Continued From page 23 Conducted a RR for R76. Review of progress notes documented R76 was admitted to the facility on 11/02/18 to 04/21/20. On 04/21/20, R76 fell in the shower which resulted in an admission to an acute hospital for a left femur fracture and underwent an Arthroplasty (surgical replacement of the joint). R76 was re-admitted to the facility on 04/25/20 with diagnoses including Adult failure to thrive, major depressive disorder, anxiety disorder, dementia with lewy bodies, history of traumatic fracture, and presence of a left artificial hip joint. R76 had two (2) unwitnessed falls which resulted in major injury (04/21/20) and redness to the left side of R76's head (11/28/20). Review of R76's care plan (CP) documents the resident is a high risk for falls/serious injury related to severe cognitive impairment. R76 presents with confusion, forgetfulness, and impaired safety awareness due to dementia, insomnia, and adverse effects of multiple psychotropic medications. The interventions include the application of floor pads on both sides of the bed, with consent from the resident's representative. On 03/15/21 at 12:35 PM, conducted an interview with Unit Manager (UM)3. UM3 confirmed floor pads should have been placed on both sides of the bed for R76 and was not. 2) On 03/09/21 at 09:50 AM, observed R76 in a common dining area seated in a wheelchair at a table which was not near the nurse's station. R76's wheelchair was positioned between a table and a wall on the unit's main dining are. The positioning of R76's wheelchair prevented R76 from moving the wheelchair in any direction or freely standing. The handlebars on the back of	4 175	is sustained. 5)Compliance will be achieved by 5/7/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. BUILDING: _____ B. WING _____	03/15/2021

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4 175	Continued From page 24	4 175		

the wheelchair were approximately one inch away from the wall making impeding the wheelchair from backward movement and the front of the wheelchair was approximately two-three inches away from the table impeding R76 from standing for moving the wheelchair forward. Observed R76 grabbing the side of the table and attempting to stand, however, the table was too close to R76 and stopped her from fully standing, R76 was not engaged in any activities and there were no staff was in the immediate area.

On 03/09/21 at 10:00 AM, inquired with Registered Nurse (RN)6 regarding R76's wheelchair being tightly placed between the table and wall, and continuous attempts to stand. RN6 stated "R76 does that." RN6 was asked to further clarify the statement and RN6 replied, R76 is always trying to stand, but the resident is confused and will fall. R76 observed seated in the wheelchair in the dining area until approximately 1:00 PM.

This surveyor made a total of five observations (03/09/21 at 09:50 AM, 03/10/21 at 09:00 AM, 03/11/21 at 09:18 AM and 4:35 PM, and on 03/15/21 at 08:00 AM) R76 same position, seated in the wheelchair which was placed between a wall and a table, attempting to stand but was physically unable to due to her positioning, and not engaged in activities..

On 03/10/21 at 1:16 PM, two surveyors observed R76 positioned the same as described above, but this time R76 was frantically grabbing at the sides of the table, pulling at the tablecloth on the table while grabbing at the side of the table, and attempting to stand up. R76 appeared extremely distressed and frightened to both surveyors making the observation. Unit staff were assisting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. BUILDING: _____ B. WING _____	03/15/2021

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4 175	Continued From page 25	4 175		

other residents and would occasionally go to the medication cart, which was in the line of sight or R76, prepare medications, then leave the area. Staff passing the main dining area did not stop to assess or help R76.

Conducted a record review (RR) of R76's electronic medical record (EMR). R76's care plan, last reviewed on 02/12/21, documented interventions which includes that staff ensures R76 is by nurse station while in wheelchair, provide table in front with snacks or activity to utilized in keeping busy to divert attention, involve in activities that promote independence, frequent check while at nurse station due to frequently stand up and sitting, and ensure the table and chair are aligned due to poor balance when standing which were not implemented. Review of the physician orders did not document restraint orders.

On 03/15/21 at 12:35 PM, conducted an interview with the Unit Manager (UM)3 regarding observations of R76' wheelchair positioned between the wall and the table which stopped R76 from freely standing. UM3 confirmed the placement of R76's wheelchair did prevent R76 from freely standing and restricted the resident's movement. Inquired if R76's wheelchair was positioned in that manner due to any medical condition. UM3 stated R76 did not have a medical condition which would require the resident's wheelchair to be placed in a manner which would restrict R76 from moving. UM3 stated R76 requires constant supervision which the staff are unable to accommodate and staff have a difficult time finding activities to keep R76 engaged due to R76's level of cognition. Inquired if R76 would benefit from the implementation of dementia care. R76 confirmed specific dementia

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	125019	A. BUILDING: _____ B. WING _____	03/15/2021

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4 175	Continued From page 26	4 175		

care would benefit the resident, however, the resident does not have a detailed dementia program or interventions.

On 03/15/21 at 2:51 PM, conducted an interview with the Director of Nursing (DON). Shared observations of position of R76's wheelchair and restricted ability to stand freely. The DON confirmed the positioning of the wheelchair did work as a physical restraint and the facility did not implement effective interventions related to R76's dementia care.

3) R35 was admitted to the facility on 06/16/20. R35's diagnoses includes pleural effusion, encephalopathy, unspecified psychosis not due to a substance of physiological condition, Type 2 diabetes mellitus with chronic kidney disease, venous insufficiency (peripheral), presence of other vascular implants and grafts, renal disease dependence on renal dialysis, liver disease, chronic diastolic (congestive) heart failure, hypertension, and Major depressive disorder severe with psychotic features.

Observed R35 resting in bed on 03/11/21 in the afternoon after returning from dialysis. R35 was positioned on the back with a single pillow placed under both legs. Observed both of R35's heels resting on the bed.

Conducted a RR of R35's electronic medical records. R35's CP documented R35 has a history of pressure injury to the left heel. Interventions include elevating R35's feet on pillows when in bed to reduce pressure on the heels, however, the use of a single pillow was ineffective in reducing the pressure to the resident's heels. Another intervention documented in the CP is for heel protectors on

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	125019	A. BUILDING: _____ B. WING _____	03/15/2021

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4 175	Continued From page 27 both feet when in bed. On 03/15/21 at 12:40 PM, inquired with UM3 regarding observations and interventions related to the reduction of pressure injuries to R35's heels. UM3 confirmed staff should ensure R35's heels should not be resting directly on the resident's mattress. Pillows are placed under R35's legs to raise the heels off the bed surface, in addition to placing both of R35's lower extremities in pressure reducing boots to further protect R35's heels from pressure injury. 4) The facility failed to provide appropriate services to maintain and improve resident (R)127's activities of daily living for eating. Observations and record review found staff members were not implementing R127's care plan for eating. Also, observation found R127 uses built-up spoon and forks which was not included in the resident's care plan. Review of R127's care plan last reviewed on 12/30/20 for eating states "Encourage, cue, assist, or feed as needed to complete at least 75% of meals ..." Interview with Registered Nurse (RN) 17 on 03/12/21 at 01:27 PM, RN17 stated that staff are expected to set up and put R127's food in front of R127 and then encourage R127 to eat independently prior to providing extensive physical assistance. RN17 did not know why R127 had Styrofoam bowls and a built-in spoon and fork and confirmed it is not in the care plan. On 03/12/21 at 03:41 PM, an interview with the DON confirmed R127's built-in spoon and fork should have been in the care plan for restorative	4 175		

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4 175	Continued From page 28	4 175		

care.

5) R25 was a 73-year-old admitted to the facility on 06/22/18 for long-term care services following a C6-C7 (sixth and seventh cervical vertebrae near the lower part of the neck) spinal cord injury. Since his admission, R25 had suffered a decline in the ROM of both his hands and feet, as a result of worsening contractures (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints).

On 03/10/21 at 10:12 AM, an observation and interview were done with R25 in his room on Unit 1. R25 was observed with both feet in a resting position of extreme plantar flexion (toes pointing towards the foot of the bed). Regarding his upper extremities, R25 noted to have advanced contractures to both hands and both wrists. R25 stated that he cannot rub his eyes, or scratch an itch, he cannot press the call light unless it is positioned in the correct spot on his chest, and he cannot re-position the call light if it is out of place. R25 also stated that he remembers being able to do more with his hands.

On 03/11/21 at 09:21 AM, an interview was done with the Restorative Nurse Aide (RNA) 2 in front of the Unit 1 Nurses Station. RNA2 stated that R25's feet cannot dorsiflex (point toes straight up and move them back towards shin) any longer, "too long they've [the feet] been like that", the joints, muscles and tendons in both lower legs have hardened.

On 03/15/21 at 11:03 AM, an interview was done with the Director of Nursing (DON) in the second floor Conference Room. DON stated that R25 received occupational therapy (OT) services that addressed his upper and lower extremity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 175	Continued From page 29	4 175		

contractures in July 2018 and Jan 2019. He has not received further OT services since signing a refusal for bilateral hand splints on 01/30/19. DON unable to produce documentation of hand supports, foot supports or refusal to wear splints ever being added to R25's CP. DON stated that "there should be continual offerings" of refused interventions and acknowledged that the orthotic supports should have been added to the CP.

6) R117 was a 66-year-old who was re-admitted to the facility on 02/11/21 following pneumonia and a complicated bacterial infection. Other diagnoses for R117 included dementia with behavioral disturbance, muscle weakness, malnutrition, respiratory failure, hypertension, history of nasopharyngeal (upper part of the throat behind the nose) cancer, and psychotic disorder with delusions. She was dependent on tube feedings for nutrition, was non-verbal, had a tracheostomy tube through which she received ventilator support as needed for respiratory distress, and was taking both an anti-depressant, and an anti-psychotic due to anxiety, agitation, resistance to care, and combativeness related to her dementia.

On 03/09/21 at 09:33 AM, an observation was made of R117 in her room on Unit 1. When greeted by the Surveyor, RN117 briefly looked, but quickly looked away and refused to make eye contact or acknowledge greetings and questions again. R117 was observed to have her eyebrows drawn together, and her lips turned downward in an angry expression the entire time Surveyor was in the room.

A review of R117's Initial MDS Assessment noted R117 had indicated that it was "Very Important" to her to have her family involved in discussions

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4 175	Continued From page 30 about her care. A review of R117's CP noted the facility identified multiple separate behavioral problems, such as " ...[R117] is resistive to care, and kicks, pinches, fights staff, refuses care ...", "Resident is ...forgetful, confused ...and does not follow commands.", "[R117] ...uses psychotropic medications d/t dementia with agitated behavior.", and "[R117] ...has anxiety/agitation, resisting ADL [activities of daily living] care ...". For each of these identified needs, the CP reflects no behavioral interventions that include or incorporate R117's family.	4 175		
4 177	11-94.1-44(a) Specialized rehabiiltation services (a) The facility shall provide for specialized and supportive rehabilitation services, including occupational therapy, physical therapy, and speech therapy, according to the needs of each resident, either directly by qualified staff or through arrangements with qualified outside resources. Services shall be programmed to: (1) Preserve and improve the resident's maximal abilities for independent function; (2) Prevent, insofar as possible, irreversible or progressive disabilities; and (3) Provide for the procurement and maintenance of assistive devices as needed by the resident to adapt and function within the resident's environment. This Statute is not met as evidenced by: Based on observations, record review, and	4 177	4177 – Specialized rehabilitation services	5/7/21

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4 177	Continued From page 31 interviews, the facility failed to ensure rehabilitaion services for Resident (R)25 to preserve the resident's maximal abilities as evidenced by R25 worsening of contractures and decline in range of movement for both hands and feet. Findings Include: R25 was a 73-year-old admitted to the facility on 06/22/18 for long-term care services following a C6-C7 (sixth and seventh cervical vertebrae near the lower part of the neck) spinal cord injury. Since his admission, R25 had suffered a decline in the ROM of both his hands and feet, as a result of worsening contractures (a shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints). On 03/10/21 at 10:12 AM, an observation and interview were done with R25 in his room on Unit 1. R25 was observed with both feet in a resting position of extreme plantar flexion (toes pointing towards the foot of the bed). Regarding his upper extremities, R25 noted to have advanced contractures to both hands and both wrists. R25 stated that he cannot rub his eyes, or scratch an itch, he cannot press the call light unless it is positioned in the correct spot on his chest, and he cannot re-position the call light if it is out of place. R25 also stated that he remembers being able to do more with his hands. On 03/11/21 at 09:21 AM, an interview was done with the Restorative Nurse Aide (RNA) 2 in front of the Unit 1 Nurses Station. RNA2 stated that R25's feet cannot dorsiflex (point toes straight up and move them back towards shin) any longer, "too long they've [the feet] been like that", the joints, muscles and tendons in both lower legs	4 177	1)Resident #25 screen showed that resident was at prior baseline. Resident was picked up RNA, and DON educated RNA staff on documentation of residents' refusals of treatments on 3/12/21. DON also educated Director of Rehabilitation (DOR) on definition of evaluation versus screening and documenting on 3/12/21. 2)Residents residing in the facility requiring rehab services have the potential to be affected. Director of Rehabilitation is conducting an audit of current resident to ensure orders for resident screens or evaluations have been completed timely and documented. 3)DON/Designee educated LNs on 4/29/21 and on an ongoing basis regarding communication of rehab services and informing them of orders timely. 4)DOR/Designee will conduct audits on 3 residents with new orders for therapy service per week x 4 weeks, then 8 residents per month x 2 months to validate orders are followed. DOR/Designee will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. BUILDING: _____ B. WING _____	03/15/2021

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THE CARE CENTER OF HONOLULU	1900 BACHELOT STREET HONOLULU, HI 96817

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4 177	Continued From page 32 have hardened. On 03/15/21 at 11:03 AM, an interview was done with the Director of Nursing (DON) in the second floor Conference Room. DON stated that R25 received occupational therapy (OT) services that addressed his upper and lower extremity contractures in July 2018 and Jan 2019. He has not received further OT services since signing a refusal for bilateral hand splints on 01/30/19. DON unable to produce documentation of hand supports, foot supports or refusal to wear splints ever being added to R25's CP. DON stated that "there should be continual offerings" of refused interventions and acknowledged that the orthotic supports should have been added to the CP.	4 177		
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications in one of the medication rooms and two medication carts were clean and sanitary, and the stored medications were current and appropriately used for residents residing in the facility. Findings Include: 1) During an observation of the VCU unit medication room on 03/11/21 at 08:37 AM with the VCU unit manager (VCU UM), it was found there was one resident, R197, whose medication	4 197	4197 – Pharmaceutical services 1)UM discarded expired medications in both VCU med carts. The VCU Med Room was also cleaned. 2)Residents residing in the facility have the potential to be affected. 3)DON/Designee re-educated Licensed Nurses on 4/29/21 and on an ongoing basis on checking medications for expiration dates and removing them from	5/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. BUILDING: _____ B. WING _____	03/15/2021

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4 197	Continued From page 33 box containing, "Ipratropium Bromide Solution 0.02 % 2.5 ml via trach every 4 hours as needed for SOB/Wheezing and 2.5 ml via trach every 6 hours for respiratory failure," should have been discarded as R197 no longer resided at the facility. The VCU UM stated R197 had been discharged a month ago and this medication should have been removed. In addition, there were several intravenous (IV) solution bags placed in a red bin on a bottom shelf in the VCU medication room. The red storage bin was not clean as there were brown and white unknown particle pieces and dust. There also were two packaged angiocaths which were found at the bottom left side of the bin with the IV bags. The VCU UM manager stated the angiocaths were to be used with the IV bags. However, when he was queried why they were in this bin and not stored as clean items with other angiocaths, he removed the packages. 2) On 03/11/21 09:15 AM, during a review of the VCU front medication cart with RN16, it was found there was one opened "Amikacin Sulfate Injunction, 4 mL vial" which RN16 said was used for R46. RN16 stated the vial was obtained from their emergency kit or "ekit." RN16 said there was "no open date" written on the vial to show when it had been used. RN16 verified it was to have been discarded as it was a one time use for this medication. RN16 discarded the vial into the medication cart's sharps container. 3) On 03/12/21 at 09:45 AM, during a review of the VCU back medication cart with RN23, a Lantus insulin pen for R40 was found with a handwritten "open date" (when it was opened for use) and an expiration date. When RN23 was asked about the dates on the insulin pen, she	4 197	the med carts and/or Med Rooms for prompt disposal, as well as discarding medications after residents are discharged from the facility. 4)Unit Manager/Designee will audit 1 Med Room and 3 Med Carts per week for 4 weeks to validate proper labeling, storage and use of pharmaceutical supplies. DON/Designee will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. BUILDING: _____ B. WING _____	03/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 197	Continued From page 34 read "3.2" on the insulin pen, but stated, "hard to read" for the actual open date and the expiration date. RN23 acknowledged it was not legible and stated the nurse who wrote it as such was responsible.	4 197		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations, interviews, and review of the COVID-19 Survey Tool, the facility failed to provide a safe, sanitary environment which prevents the development and transmission of communicable diseases and infections by failing to ensure a visitor used the appropriate personal protective equipment (PPE) while within the facility and in close proximity to residents as evidenced by observation of R76's family member not wearing a mask while in close proximity to R76 and R76's roommate, failing to ensure oxygen tubing used for R145 was appropriately labeled, failing to ensure staff wear the proper PPE when performing tracheal suctioning, and failing to ensure staff changed out tube feeding (TF) administration sets every twenty-four hours, as recommended by the manufacturer. As a result of these deficient practices, all residents and staff are at risk for the development and transmission of COVID-19 and other communicable diseases and infections.	4 203	4203 – Infection control 1)Resident #76's family member was educated on 3/15/21 regarding the importance of social distancing and wearing a proper face covering. Resident #145 was given a new tubing and was labeled with the date. Resident #1 formula and tubing were replaced immediately. RN #33 was educated on 3/15/21 regarding importance of proper hand hygiene during med administration. Resident #13's trache tubing was replaced and labeled with date. RT #20 was educated on 3/9/21 on the need to wear PPE properly. Resident #25 TF administration set was replaced and labeled. RN #23 was educated on 3/10/21 on following the facility's policy for enteral feedings-safety precautions. CNA #81 was educated on 3/10/21 on following	5/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 203	Continued From page 35 Findings Include: 1) On 03/15/21 after lunch, observed R76's Family Member (FM) in R76's room. FM was cutting R76's toenails (within 6 feet) and was not wearing a face mask. The FM's N95 mask which was provided by the facility was placed down on R76's bedside table. Upon seeing the surveyor, the FM pulled up cloth material which was hanging around the FM's neck. In addition, the FM was observed to be within six (6) feet of one (1) of two (2) resident roommates who was present in the room. On 03/15/21 at approximately 2:00 PM, conducted an interview with the Infection Preventionist (IP). The IP stated all visitors are screened at the front door for recent travel, signs and symptoms related to COVID-19, exposure to COVID-19, and their temperature is taken, and visitors are required to wear N95 mask (provided by the facility) at all times while within the facility. Shared observations of R76's visitor in the room with R76 and one (1) of two (2) resident roommates, with no face covering. R76's Family Member (FM) had removed the N95 mask and placed it down on R76's bedside table. The FM was within six (6) feet of R76, near the foot of R76's bed, and within six (6) feet of the roommate nearest to the window. Inquired if the facility implemented a system to monitor and ensure visitors following and implementing the facility's infection control protocols while within the facility. The IP confirmed the facility does not have a system in place or procedures which monitors to ensure visitors are complying with the facility's infection control protocols. Furthermore, inquired with the IP, if the visitor was fitted for the N95 mask that was provided by the facility. The IP	4 203	disinfecting guidelines to prevent cross contamination of clean and unclean stations. Huddled staff on 3/11/21 regarding proper labeling, storage, and disposal of face shields. There were no adverse outcomes. 2)All residents have the potential to be affected. 3)DON/Designee educated staff on 4/29/21 and on an ongoing basis regarding the importance of maintaining social distance while on their breaks, their responsibility to inform Visitors when they are not complying with Visitor expectations, and proper use and disposal of eye protection. DON/Designee also educated licensed staff on 4/29/21 regarding proper hand hygiene during medication administration and requirements for labeling of enteral, trache, and oxygen tubes. Social distancing signage were placed by timecard and in break areas. 4)DON/Designee will conduct observation audits on 5 staff member interactions and 5 visitor interactions per week x 4 weeks, then 10 staff/visitors per month x 2 months to validate that facility policy is being followed. DON/Designee will conduct audits on 10 residents with orders for enteral, trache, or oxygen tube per week x 4 weeks, then 10 residents per month x 2 months to validate that tubing is properly labeled and that order to change tubing is being followed. DON/Designee will report on any tends and findings to QAPI Committee for further resolution and	

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	125019	A. BUILDING: _____ B. WING _____	03/15/2021

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4 203	Continued From page 36 confirmed visitors are not fitted and acknowledged the use of an N95 that is not fitted will not provide the same level of protection as the use of an N95 that is fitted for that individual's use. 2) On 3/10/21 at 08:52 AM, observed R145 resting in bed with nasal cannulas applied. The oxygen tubing and nasal cannula were not labeled with the date. Review of R145's electronic medical records documents an order to change oxygen tubing every Thursday and label with the date. On 3/11/21 at 12:43 PM, conducted and interview and observation of R145's tubing with Unit Manager (UM)3. UM3 confirmed R145's oxygen tubing or nasal cannula were not labeled and should have been. UM3 also acknowledged the infection control risk for residents who's oxygen tubing is not changed out regularly, as needed, and according to manufacturer's recommendations. 3) On 03/11/21 at 12:42 PM, observed R1's enteral set-up. A bag of Diabetic Source AC set-up for R1, dated 03/08/21 at 21:00 (9:00 PM), and was labeled with R1's information. On 3/11/21 at 12:43 PM, conducted an interview with Unit Manager (UM)3. UM3 stated the time and date on the enteral nutrition represents when the nutrition was set-up for use. The formula and tubing are good for 48 hours after the date and time staff labels it. UM3 inspected the Diabetic Source AC formula which was hanging for R1. UM3 confirmed the formula and tubing is expired and should be replaced. UM3 stated the tubing connected to the formula is not changed out after	4 203	recommendation until the committee validates compliance is sustained. 5)Compliance will be achieved by 5/7/21.	

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4 203	Continued From page 37 a bag is spiked, it is a closed system. Review of R1's electronic medical record with UM3 documented R1 received five (5) administrations (03/10/21 at 00:17 AM, 10:39 AM, 09:58 PM, and 11:50 PM; 03/11/21 at 2:02 PM) of 330 ml from the expiring enteral formula and expired tubing. Review of the facility's policy and procedure documented sterile formula in a closed system has a maximum hang time of 48 hour. The administration set (tubing system) changes documented the change administration sets for closed-system enteral feedings are according to the manufacturer's recommendation. Review of the manufacturer's recommendation on changing the administration set is 24 hours. According to the manufacture's recommendations the tubing set should have been changed on 03/09/21 at 9:00 PM. 4) On 03/15/21 at 12:00 PM, observed Registered Nurse (RN)33 during medication preparation and medication administration. RN33 did not perform hand hygiene after using a shared computer at the nurse's station and preparing medications for Resident (R)100. In addition, RN33 did not perform hand hygiene prior to administering medications to R100. In another observation, RN33 administered medication to R789, did not perform hand hygiene after touching the rim of a cup of water used by the resident. RN33 then proceeded to use the computer on the medication cart without performing hand hygiene. 5) An initial observation of R13 was done on 03/09/21 at 08:39 AM in her room. R13 was lying in bed sleeping. She had a tracheostomy (a surgically formed opening into the windpipe to allow breathing) through which she was receiving	4 203		

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4 203	Continued From page 38	4 203		

oxygen through. The oxygen was being delivered through tubing attached to a tracheostomy mask that were not dated.

Another observation of R13 done on 03/10/21 at 09:12 AM found that the tracheostomy mask nor the oxygen tubing were dated.

A third observation of R13 was done on 03/11/21 at 08:00 AM and her tracheostomy mask and oxygen tubing were found not dated.

A concurrent observation and interview with RT20 were done on 03/11/21 at 08:30 AM. Surveyor asked RT20 if R13's oxygen equipment, that R13 is currently utilizing, should be dated and RT20 stated, "Yes." She stated that R13 goes to hemodialysis treatments on Monday, Wednesdays and Fridays and that R13's dated oxygen equipment was probably in a bag she takes to her treatments.

6) A modified resident council meeting was conducted on 03/10/21 at 09:58 AM. R4, R14, R27, R72, R94, and R118 were in attendance. R4 stated that it was unfair that residents had to socially distance for COVID-19 precautions when the staff were not following the same protocol. R4 then stated, "Look outside." Adjacent to the dining room, where the resident council meeting was conducted, was an outdoor patio area. Surveyor stood up so that she could see around the curtain partially covering the glass window. Surveyor saw five staff members not wearing masks, sitting less than 6 feet apart, eating their meal at the same table.

On 03/10/21 at 11:34 AM, an inquiry with the IP was made regarding staff taking their meal breaks and the facility's COVID-19 protocol. She

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4 203	Continued From page 39	4 203		

stated, "They shouldn't be congregating together for lunch."

An interview was conducted with RN3 on 03/11/21 at 10:50 AM at the nursing station of Unit 2. Surveyor asked her where staff take their meals breaks. She stated that they take their meal breaks on the "lanai" (outdoor patio) next to the resident's dining room. When asked if staff are required to social distance during their meal breaks, she stated, "Yes."

7) On 03/09/21 at 10:46 AM, an observation and interview were done of Respiratory Therapist (RT) 20 performing tracheal suctioning (suctioning of a tube in the throat that is surgically inserted through the neck) on Resident (R) 117, at the bedside on Unit 1. RT was observed wearing a gown, gloves, respirator, and eyeglasses with no eye protection over it while performing the procedure. During the procedure, R117 was observed with a large (approximately a half dollar in size), thick, dark beige, glob of mucus ooze out from around her tracheal tube onto the lower part of her neck. After the procedure was done, and R117 had been cleaned, RT20 was asked about eye protection. RT20 stated she usually does wear eye protection, "I have it, I just forgot."

A record review (RR) of the Facility Infection Control Standard Precautions Policy & Procedure, last revised 7/1/2020, noted the following regarding eye protection: Mask and eye protection or a face shield are worn to protect mucous membranes of the eyes, nose, and mouth during procedures and resident-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

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4 203	Continued From page 40 8) On 03/09/21 at 11:43 AM, an observation was done at the bedside of R25 on Unit 1. Observed R25's TF connected to the pump. The TF administration set (tubing set inserted into the TF bag, through the pump, and connected to R25's gastrostomy tube) was labeled "3/7/21 0630." On 03/10/21 at 09:08 AM, an interview was done with Registered Nurse (RN) 23 in room 107. RN23 stated that the facility policy is TF bags can be used for 48 hours after puncture, and the administration sets are changed out at the same time as the bags. RR of the facility policy Enteral Feedings-Safety Precautions, dated 3/2/21, notes "Administration set changes: Change administration sets for closed-system enteral feedings according to manufacturer's instructions." On 03/12/21 at 01:13 PM, an observation was made of a sealed TF administration set used in the facility. Noted to be a Coviden Epump ENPlus Spike Set with clear printed manufacturer instructions, "Do not use for greater than 24 hours". 9) On 03/10/21 at 09:01 AM observed Certified Nursing Assistance (CNA) 81 slightly open the door of room 200, an identified person under investigation (PUI) room (new admission), after doffing face shield and gloves. Resident in room 200 was observed through the opened door to be washing hands at the sink next to the door. CNA81 grabbed the food tray from the wash basin counter in the room and put it on the clean supply station containing clean personal protective equipment (PPE) and used for donning PPE. CNA81 reached for alcohol-based hand rub and picked up the food tray from the supply	4 203		

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4 203	Continued From page 41 station and put it away in the food cart. CNA81 did not return to disinfect the supply station. 10) Observed concurrently with Registered Nurse (RN) 17 on 03/11/21 at 10:08 AM of the medication storage room on Unit 4, three unmarked and uncovered face shields were found on the right bottom shelf in the storage room. Two of the face shields were in a small box with other supplies touching each other and one of the face shields was on a shelf laid upon a napkin. The face shield laid upon the napkin with streaks of water marks. RN17 proceeded to take the three face shields and stated she they need to be thrown in the trash because they are unmarked. RN17 stated that staff are supposed to put their face shields in their designated bag. RN17 did not feel the masks were dirty because the nursing staff are supposed to clean them after use. Concurrent observation of the cabinet the masks were left in, RN17 stated the cabinet is a not entirely clean 11) On 03/11/21 at 09:31 AM, during a review of the VCU medication room, the door to the room had many face shields placed in clear plastic bags hanging from several hooks. However, in between the plastic bags were some face shields that were not in plastic bags and were hung by the straps of the shields onto the door hooks. The VCU UM manager stated the clean face shields were in the plastic bags and that the ones not in bags were also clean. But, a black umbrella and a white paper bag were also found hanging amongst the these face shields. The VCU UM observed this and then acknowledged the presence of the other random items that were not bagged as clean items; yet bunched together with the "clean" bagged and unbagged face	4 203		

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4 203	Continued From page 42 shields.	4 203		
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe, clean environment for the residents and staff at the facility, as evidenced by a leaking air conditioner in room 106, and a missing doorknob to the main door of room 101. As a result of this deficient practice, the staff and residents were placed at risk for avoidable injuries. This deficient practice has the potential to affect all the residents and staff at the facility. Findings Include: 1) On 03/09/21 at 09:50 AM, an observation was done of the main door to room 101. The Resident (R)397 in the room was a new admission, so the room door was kept closed per the facility's COVID-19 Infection Control protocol. Observed that the main door had no doorknob, just an empty hole with rusted edges, not smoothed out. Noted that a person could push the door open when entering, but in order to exit the room, a hand had to be placed in the empty hole to pull it open. 2) On 03/11/21 at 09:05 AM, an observation and interview were done in room 106 with Registered Nurse (RN) 23. Observed a leaking air conditioning unit (AC), dripping water into a corner of the room. Several bed pads and a medium-sized trash can, half-filled with water,	4 243	4243 – Engineering and maintenance 1)The door knob in room 101 and the A/C in room 106 was immediately repaired. 2)Residents residing in the facility have the potential to be affected. 3)Administrator/Designee educated staff on 4/29/21 and on an ongoing basis regarding the importance of providing a clean, safe and comfortable environment. Staff are to utilize the maintenance log to report items that need to be fixed to provide a homelike environment. Maintenance staff will check logs daily and will initial/date upon completion. 4)Director of EVS will observe 5 resident rooms per week x 4 weeks, then 10 rooms per month x 2 months to validate that there are no items in disrepair. Director of EVS will check maintenance logs weekly for two months to ensure proper follow-up has been made. Administrator/Designee will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained.	5/7/21

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4 243	Continued From page 43 were observed on the floor under the AC. The AC was positioned in the corner above where the glass door closes. Observed the floor tiles in the corner were very wet with a buildup of black crud between the tiles. RN23 reported that Maintenance had been working on repairing the AC for a while. RN23 also stated that Housekeeping comes into the room periodically to empty the water from the trash can, and to replace the bed pads on the floor. 3) On 03/11/21at 11:34 AM, an interview was done with the Lead Maintenance worker (LM) 1 at the Unit 1 Nurses Station. LM1 reported that he just finished replacing the doorknob on room 101. Stated the doorknob was removed a week ago because it got stuck in the locked position (no resident was in there at the time). Regarding the leaking AC in room 106, LM1 could not find documentation of a work order in the Maintenance logbook for the problem, but stated he was aware of it. Reported that the AC needed to be re-aligned to stop it from dripping. The job would require at least two maintenance workers to complete, and since Maintenance only has three staff, it would probably be another two weeks before they could get to the repair.	4 243	5)Compliance will be achieved by 5/7/21.	
4 246	11-94.1-64(d) Engineering and maintenance (d) The facility shall maintain records that document that inspection of all devices essential to the health and safety of residents and personnel shall be carried out at sufficient intervals to ensure proper operational performance. This Statute is not met as evidenced by: Based on observations, interviews, and record	4 246	4246 – Engineering and maintenance	5/7/21

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4 246	Continued From page 44 review, the facility failed to maintain records that document that inspections related to the safety of the residents and staff be carried out at sufficient intervals to ensure proper operational performance as evidenced by the facility's water temperature logs were not adequately maintained and water temperature was within safe temperatures. As a result of this deficiency, all residents and staff are at risk of sustaining serious injury and burns due to extremely hot water temperatures. Findings Include: A modified resident council meeting was conducted on 03/10/21 at 09:58 AM. R4, R14, R27, R72, R94, and R118 were in attendance. R118 stated that the hot water was "hot" on the second floor where he resided. Few of the other residents who resided on either the first or second floors concurred with him. On 03/12/21 at 08:11 AM, surveyor called LM and requested the facility's water temperature logs. He stated that he would look for their logs. Surveyor queried as to who was the maintenance director and he stated that the Administrator was their department leader. On 03/12/21 at 08:22 AM, surveyor spoke to the Administrator and he stated that LM will meet with the surveyor after he sets up for resident's visitations. While waiting for LM on Unit Two, surveyor queried RT3 at 09:17 AM regarding the facility's hot water. She stated that she turns on both the hot and cold water for a tolerable hot water temperature.	4 246	1)Resident #76 was assessed by UM and care plan was updated to allow resident to move more freely with adequate supervision. The hot water issue was addressed by calling the commercial plumber and adjusting the mixing valve. 2)Residents residing in the facility have the potential to be affected. After the mixing valve was fixed on 3/12/21, all resident rooms and resident shower rooms were tested for water temperature safety below 120 degrees. 3)DON/Designee educated staff on 4/29/21 and on an ongoing basis regarding meeting the emotional and physical needs of residents while ensuring that they are free from potential accidents. Administrator/Designee educated maintenance staff on 4/29/21 regarding the importance of maintaining proper water temperature logs. 4)Administrator/Designee will conduct weekly observation rounds of nursing units x 4 weeks to validate that the facility is free of potential accidents and hazards. Director of Environmental Services (EVS) will conduct weekly water temperature audits x 4 weeks to validate that temperature logs are being maintained and temperatures are appropriate. Administrator and Director of EVS will report any identifying trends and findings to QAPI Committee for further resolution and recommendation until the committee validates compliance is sustained.	

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4 246	Continued From page 45 At 03/12/21 at 09:41 AM, surveyor met with LM in room 129 of Unit Two. He stated that he could not find the facility's water temperature logs. He then proceeded to turn on the hot water. Steam could be seen coming from the sink. LM placed his temperature probe into the hot water stream and the digital reading displayed "71.9 C" (71.9 degrees Celsius or 161.4 degrees Fahrenheit). Surveyor and LM went to room 136 of the same nursing unit to check the hot water. LM's temperature probe displayed 129.5 degrees Fahrenheit (F). LM stated that the circulating pump for the water had been broken and was fixed three weeks ago. He had been doing water temperature checks but was not logging them. He stated that the boiler for the water is on the roof so the hottest water would be on the second floor and water going down the center of the nursing units. The hot water would become cooler as it flowed away from the center. On 03/12/21 at 09:51 AM, the hot water was checked in room 115 of Unit One. The temperature probe read 128.3 degrees F. On 03/12/21 at 11:10 AM, the State Agency (SA), Administrator and LM checked room 206's hot water temperature. It was verified to be 129.5 degrees F. The resident shower located on Unit Three registered at 116 degrees F. The Administrator stated that the mixing valve was adjusted approximately two minutes prior to checking the water temperature in room 206. He also stated that the initial setting temperature of the facility's boiler was set at 115 degrees F. On 03/12/21 at 11:56 AM, surveyor asked the Administrator for the facility's policy on Water	4 246	5)Compliance will be achieved by 5/7/21.	

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4 246	Continued From page 46 Temperatures. On 03/12/21 at 12:15 PM, SA informed the Administrator and DON of an Immediate Jeopardy (IJ) situation regarding the facility's hot water temperatures. The Administrator was informed by SA that an abatement plan for this situation needed to be presented to SA by the end of the working day. On 03/12/21 at 4:40 PM a meeting with SA and the Administrator was held. The Administrator stated that on 03/02/21, a contracted service worked on the facility's water heating system and the cold-water supply was not turned back on after repairs were completed. Timeline/plan to remedy the facility's hot water temperatures on 03/12/21 was as follows: - At 3:00 PM, a plumber was called to assess and fix the situation. - At 4:00 PM, the plumber assessed the incident and found that the cold water connected to the mixing valve was turned off. He turned on the cold-water supply and adjusted the mixing valve and boiler settings. - The hot water heaters were purged to allow the hot water to escape from the system. - Temperature readings at 4:30 PM, taken in room 115 - 88 degrees F, room 129 - 88 degrees F, and room 136 - 88 degrees F. - The maintenance team is slowly adjusting the hot water temperatures until an ideal temperature of 110 degrees F is achieved. - A nursing assessment of residents in rooms 115, 129 and 136 were done and documented to verify that none of them sustained harm from the unsafe hot water temperatures. - A letter was given to the residents of the facility notifying them that repairs were being made to the facility's water system.	4 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. BUILDING: _____ B. WING _____	03/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARE CENTER OF HONOLULU	1900 BACHELOT STREET HONOLULU, HI 96817

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4 246	Continued From page 47 - A meeting was conducted with the facility staff notifying them of the situation. SA accepted the facility's abatement plan and determined that it was operationalized on 03/12/21 at 5:00 PM. A final record of hot water temperatures taken in every resident room and resident shower rooms on 03/15/21 was reviewed on 03/15/21 at 2:30 PM. The hot water temperatures were verified to be less than 112 degrees. The facility's policy on "Water Temperatures, Safety of" revised in December 2009 was reviewed on 03/15/21 at 2:40 PM. It stated, "1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees F, or the maximum allowable temperature per state regulation."	4 246		